Central East **LHIN**

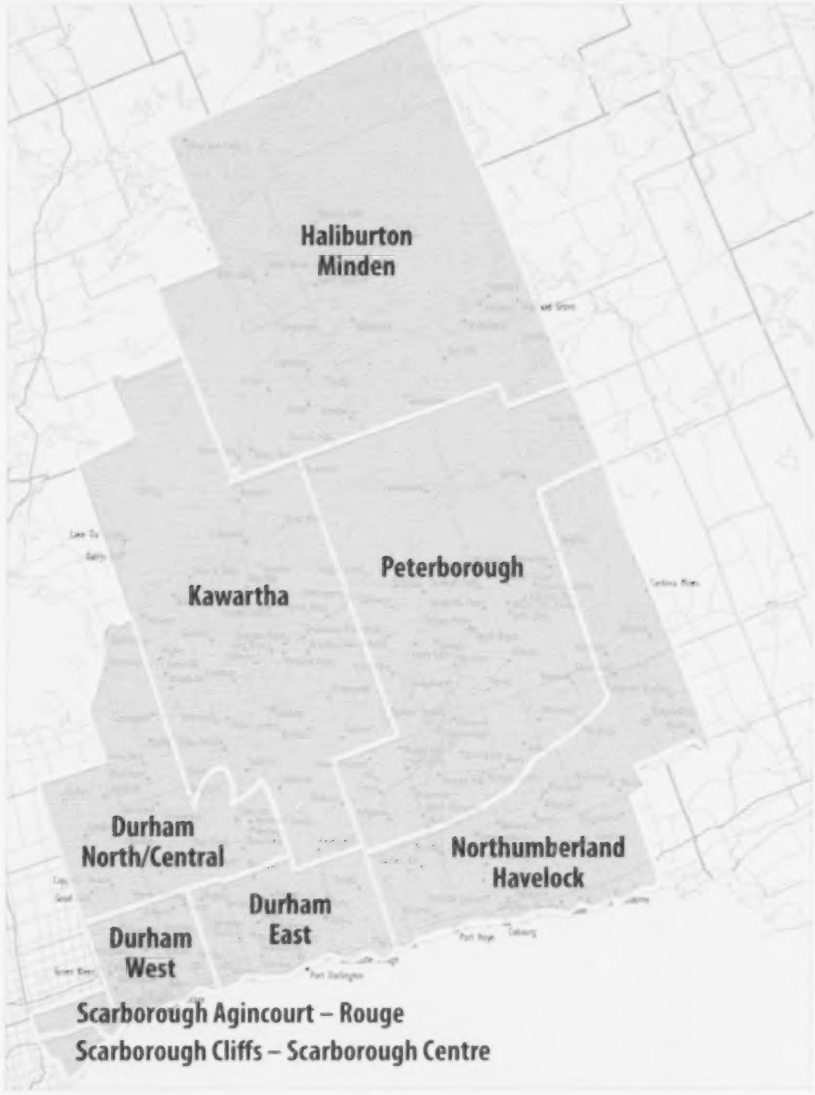
Authenticity, Abundance and Alignment

Engaged Communities. Healthy Communities.

Central East LHIN 2008-09 Annual Report

Ontario
Local Health Integration Network

CENTRAL EAST LOCAL HEALTH INTEGRATION NETWORK (9)



The Local Health Services Integration Act, passed in March 2006, is intended to provide an integrated health system to improve the health of Ontarians through better access to high quality health services, coordinated health care and effective and efficient management of the health system at the local level by Local Health Integration Networks (LHINs). LHINs are responsible for planning, integrating and funding health care providers (hospitals, long-term care homes, community support services, community health centres, Community Care Access Centres and community mental health and addictions agencies) in their specific geographic areas. LHINs received funding authority and the funding responsibility for their providers on April 1, 2007. This is the second Annual Report for the LHINs with their full authorities.

For more information about LHINs, including frequently asked questions, visit the LHINs' web site at www.lhins.on.ca

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MESSAGE FROM OUR CHAIR AND CEO

This year's Annual Report – "Authenticity, Abundance and Alignment" – takes its title from the LHIN's June 2008 Symposium and serves as a testament to the dedication of health care service providers, community leaders, patients, clients, consumers and their families who have stepped forward to begin transforming the health care system.

The theme of **Abundance** is probably the most difficult to imagine or recognize in our current health care landscape of limited funding, fiscal pressures, inequity and historical deficits. But clearly we are a LHIN of tremendous abundance simply because of the amazing variety of people who continue to bring their unique experiences and knowledge to help care for patients and residents everyday.

Alignment means to bring a particular group into a cooperative agreement with others and some may say is the real guiding purpose of local health integration networks themselves. At the Central East LHIN we believe that the foundation of any alignment is the priorities for change identified in the Strategic Directions and the Integrated Heath Service Plan (IHSP).

We require and depend upon all health service providers to align and support these broad based goals and performance objectives and this dependence is reinforced through the development of accountability agreements – both between the Ministry of Health and Long-Term Care and the LHIN and then between the LHIN and local health service providers. It is only when we are able to align our strategies and resources that we can begin to align and better coordinate the continuum of health services required by people living and working in the Central East region.

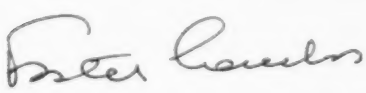
In 2008/09 one of the most important alignment projects was the development of the Hospital Clinical Services Plan. Through this Plan hospitals worked in partnership to develop "one acute care network" with a vision of "improved and equitable patient access to an integrated hospital system that provides the highest quality of care across the Central East LHIN." Hospitals' efforts to implement the recommendations contained in the Plan will now carry into 2009/10.

Authenticity can be described as the "quality of being authentic, genuine and valid, and expressing one's thoughts honestly and genuinely." At the basis of authenticity in the Central East LHIN is our commitment to community engagement. Community engagement is what we do in the Central East LHIN. It is who we are. Community engagement is what makes possible our abundance. It is how we pursue alignment.

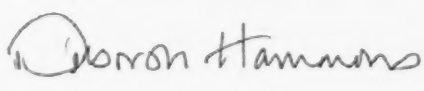
In 2008/09, with a new language and symbols of **Authenticity, Abundance, and Alignment,** we believe that we uncovered powerful forces of innovation and genuine change.

As we supported the process of authentic community engagement, people began to understand that addressing the enduring challenges in our health care system required new thinking and a willingness to engage in new conversations and partnerships. No longer does any one part hold the solution for the whole - rather the solution lies within the collective abundance of the system itself. A collection of parts working independently results in a dialogue of "scarcity" and "competition" - whereas a collection of parts working together as a system reveals a richness of intellect and resources. By putting this together, the health care system can truly start to align itself towards common goals and a single vision on behalf of the people who use it.

Thank you for your ongoing support in transforming the health care system.



Foster Loucks,
Chair



Deborah Hammons,
CEO

MEMBERS OF THE BOARD

Foster Loucks	Term of Office: June 1, 2005 – May 31, 2008 Reappointed: April 1, 2008 – June 1, 2011
Joseline Sikorski	Term of Office: June 1, 2005 – May 31, 2008 Reappointed: April 1, 2008 – June 1, 2011
Jean Achmatowicz MacLeod	Term of Office: June 1, 2005 – May 31, 2008 Reappointed: April 1, 2008 – June 1, 2011
Novina Wong	Term of Office: January 5, 2006 – February 4, 2007 Reappointed: February 5, 2007 – February 4, 2010
Stephen Kylie	Term of Office: March 1, 2006 – February 29, 2008 Reappointed: March 1, 2008 – February 28, 2011
Dr. Alexander Hukowich	Term of Office: May 17, 2006 – June 16, 2007 Reappointed: June 17, 2007 – June 16, 2010
William Gleed	Term of Office: May 17, 2006 – June 16, 2007 Reappointed: June 17, 2007 – June 16, 2010
Ronald Francis	Term of Office: May 17, 2006 – May 16, 2008 Reappointed: May 17, 2008 – May 16, 2011

The governance structure for the LHINs is set out in the Local Health System Integration Act, 2006. LHINS operate as not-for-profit organizations governed by a board of directors appointed by the province.

Each LHIN has a maximum of nine board members appointed by the Lieutenant Governor in Council. Members hold office for a term of up to three years and may be re-appointed for one additional term. The Lieutenant Governor in Council is responsible for designating the Chair and at least one Vice-Chair from among the members.

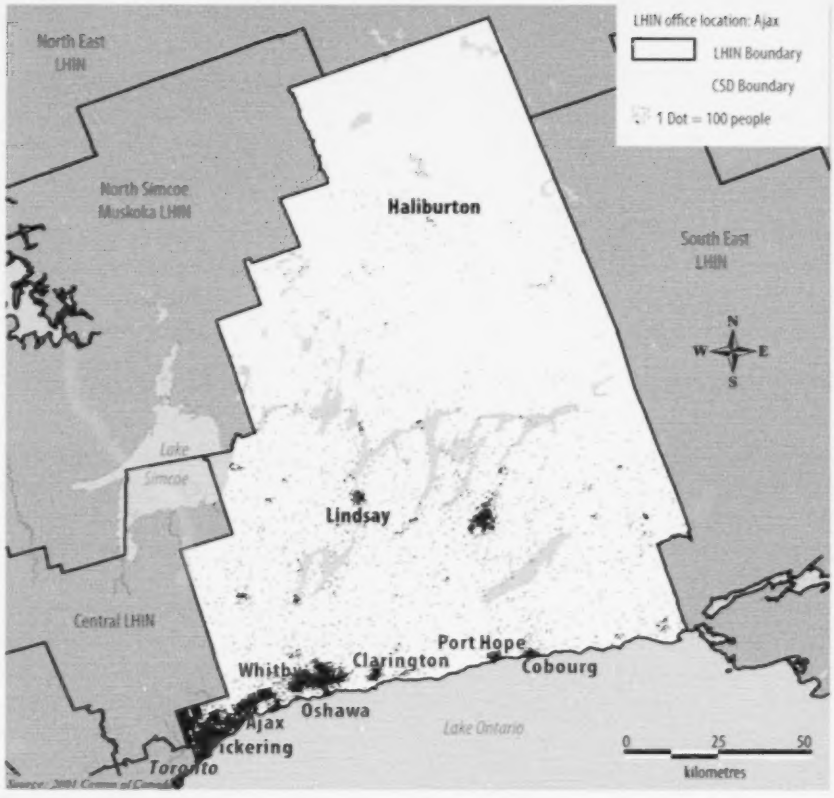
The board of directors is responsible for the management and control of the affairs of the LHIN and is the key point of interaction with the Ministry. The board may pass by-laws and resolutions and may establish committees. Certain by-laws may require the Minister's approval. Details on the Central East Board of Directors can be found on the Central East LHIN web site at: http://www.centraleastlhin.on.ca.

INTRODUCTION

The Central East LHIN is one of 14 Local Health Integration Networks that have been established by the Government of Ontario as community-based organizations to plan, co-ordinate, integrate and fund health care services at the local level including hospitals, long-term care homes, community care access centres, community support services, community mental health and addictions services and community health centres.

The Central East LHIN is one of the fastest growing geographic regions in the Province and home to approximately 11% of Ontario's population. The Central East LHIN is a mix of urban and rural geography and is the sixth-largest LHIN in land area in Ontario (16,673 km^2). In densely populated urban cities, suburban towns, rural farm communities, cottage country villages and remote settlements, the Central East LHIN stretches from Victoria Park to Algonquin Park!

Population Map



Source: MOHLTC Health Analytics Branch

The neighbourhoods in our planning zones boast a rich diversity of community values, ethnicity, language and socio-demographic characteristics.

	CENTRAL EAST	ONTARIO	LHIN Range
Total population (2006)†	**1,484,300**	**12,687,000**	**238,000 - 1,604,900**
Senior population, age 65+ (2006)‡	13.2%	12.9%	9.0 - 16.7%
Population with English mother tongue	74.5%	71.9%	55.7 - 92.2%
Population with French mother tongue	1.5%	4.7%	1.2 - 25.1%
Population who are immigrants	32.0%	26.8%	6.4 - 45.7%
Population who are recent immigrants (arrived between 1996-2001)	5.7%	4.8%	0.3 - 9.7%
Population who are visible minorities	30.2%	19.1%	1.3 - 38.8%
Population of Aboriginal identity	0.9%	1.7%	0.3 - 13.9%
Labour force participation rate (age 15+)	66.3%	67.3%	60.0 - 72.0%
Unemployment rate (age 15+)	6.7%	6.1%	5.0 - 9.8%
Population in low income	14.8%	14.4%	10.0 - 22.3%
Families (with children) headed by a lone parent	24.4%	23.4%	19.4 - 30.0%
Population (age 20+) with less than grade 9 education	7.7%	8.7%	6.3 - 12.0%
Population (age 20+) without high school graduation certificate	26.5%	25.7%	19.2 - 33.4%
Population (age 20+) with completed post-secondary education	46.2%	48.7%	42.4 - 55.8%

Source: †2006 Population estimates, MOHLTC Provincial Health Planning Database. Remaining indicators based on 2001 Census of Canada.

MINISTRY/LHIN ACCOUNTABILITY AGREEMENT (MLAA)

What is an MLAA?

The Central East Local Health Integration Network (CE LHIN) and the Ministry of Health and Long-Term Care (MOHLTC) have negotiated and signed an accountability agreement which defines the obligations and responsibilities of both the LHIN and the Ministry for the period 2007/08 to 2009/10. The Ministry/LHIN Accountability Agreement (MLAA) includes a number of schedules which outline expectations of the LHIN regarding Community Engagement; Planning and Integration; Local Health System Management; Financial Management; Local Health System Performance and eHealth.

The MLAA is mirrored in the Accountability Agreements that LHINs have already negotiated with some health service providers.

MLAA Performance Indicators

The *Ministry-LHIN Accountability Agreement* clearly defines the relationship between the Ministry of Health and Long-Term Care and the CE LHIN in the delivery of local health care programs and services. It establishes a mutual understanding between the Ministry and the LHIN and outlines respective performance targets within a pre-defined period of time.

The following table outlines CE LHIN performance against targets for 2008/09.

Central East LHIN MLAA Performance 2008/09

Performance Indicator	LHIN 08/09 Starting Point	LHIN 08/09 Target	Most Recent Quarter 2008/09*	Annual Results**	LHIN Met Target YES/NO
1. 90th Percentile Wait Times for Cancer Surgery	50	45	52	51	NO
2. 90th Percentile Wait Times for Cardiac By-Pass Procedures	-	-	-	-	-
3. 90th Percentile Wait Times for Cataract Surgery	150	150	118	123	YES
4. 90th Percentile Wait Times for Hip Replacement	250	210	138	184	YES
5. 90th Percentile Wait Times for Knee Replacement	286	210	153	188	YES
6. 90th Percentile Wait Times for Diagnostic MRI Scan	109	74	81	83	YES
7. 90th Percentile Wait Times for Diagnostic CT Scan	53	28	29	32	YES
8. Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC)	284.81	280.00	279.62	270.96	YES
9. Median Wait Time to Long-Term Care Home Placement -All Placements	63.00	45.00	105.00	86.00	NO
10. Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution	14.10	10.75	16.46	14.91	NO
11. Rate of Emergency Department Visits that could be Managed Elsewhere	17.86	11.79	17.82	16.56	NO
12. Readmission Rates for Acute Myocardial Infarction (AMI)	4.33	3.80	3.98	4.01	YES

Note: The success of CE LHIN in meeting performance targets for each MLAA indicator is assessed taking into account an upper limit performance corridor (i.e. performance target + X%).
*Performance indicators 1-7 = Q4 2008/09; and 8-12 = Q3 2008/09
**Performance indicators 8-12 (in the Annual Results Column) only include the average of Q1-3

At the end of 2008/09, the Central East LHIN was unable to achieve four performance targets identified in its MLAA. A description of these four targets and an explanation for the variance follows:

Performance Indicator #1
90th Percentile Wait Times for Cancer Surgery
There are three hospitals who reported higher than normal cancer surgery wait times: Lakeridge Health Corporation (LHC), Rouge Valley Health System (RVHS) and The Scarborough Hospital (TSH) (trending upwards). This can be attributed to temporary Health Human Resource challenges.

Northumberland Hills Hospital (NHH) experienced a higher than normal wait time in the third quarter but as of the fourth quarter, wait times had decreased to well below both the provincial and CE LHIN targets.

Performance Indicator #9
Median Wait Time for Long-Term Care Home Placement
CE LHIN was unable to achieve both the LHIN and provincial targets throughout 2008/09. The trend for this indicator increased through the year and reached a high of 105 days in the fourth quarter.

Cultural preferences for various Long-Term Care Homes such as Yee Hong (Chinese Home) have a very long wait time (e.g. 4 to 5 years). Hard to serve populations, which may include patients characterized with aggressive behaviours, sexual behaviours and mental health conditions, created pressures on the wait times within CE LHIN. The Central East Community Care Access Centre (CE CCAC) experienced one of the highest number of 1A Status (priority for placement category) clients in the province.

Performance Indicator #10
Percentage of Alternate Level of Care (ALC) Days – By LHIN of Institution:
The percentage of ALC days for hospitals in the Central East LHIN was 16.46% based on quarter one to quarter three data. This value was greater than the LHIN performance target of 10.75% and fell above the performance corridor (11.83%).

This variance was not unexpected as hospitals reported ongoing challenges related to limited patient placement opportunities in our communities. In an effort to monitor and improve this performance, the LHIN created and implemented "The ALC Tool". This tool enables each hospital to enter their weekly ALC snapshot to a centralized web-enabled database and view performance reports. Furthermore, a monthly teleconference continues to be facilitated by the LHIN to discuss issues related to ALC performance.

Other initiatives related to ALC are outlined on page 16.

Performance Indicator #11
Rate of Emergency Room (ER) Department Visits that can be Managed Elsewhere
Although not meeting the MLAA target, CE LHIN demonstrated some improvements from the start of the fiscal year and showed an improvement in visits diverted from the ER from the third quarter to the fourth quarter. Volumes for patients with mental and behavioural disorders decreased significantly for several sites from the start of the fiscal year to the third quarter.

Current and planned initiatives such as Pay for Results, Aging at Home and Urgent Priorities Funding (working collaboratively with both health service providers and CE LHIN staff) will continue to facilitate the diversion of ED visits that can be managed elsewhere in the CE LHIN.

Close monitoring continued with a particular emphasis on Ross Memorial Hospital and Peterborough Regional Health Centre (highest volumes of avoidable ER visits for 2007/08) as well as patients in age groups one to nine and 15 to 24.

Central East LHIN Integrated Health Service Plan (IHSP)

In November 2006, when the Central East LHIN released its Integrated Health Service Plan, it stated that "this initial Integrated Health Service Plan is focused on system design with a focus on key health care priorities for change." The Plan provided "upstream" strategies – such as disease prevention and management, housing, cultural competency - which will reduce unnecessary use of limited and more expensive health care services "downstream."

Implementation of the IHSP

In 2008/09, health service providers, patients and stakeholders from across the region continued to work on projects related to the implementation of the Integrated Health Service Plan through funding provided by the Ministry of Health and Long-Term Care (MOHLTC) and the LHIN. These projects specifically benefited identified populations in three priority areas – Seamless Care for Seniors; Chronic Disease Prevention and Management; and Mental Health and Addictions.

Seamless Care for Seniors

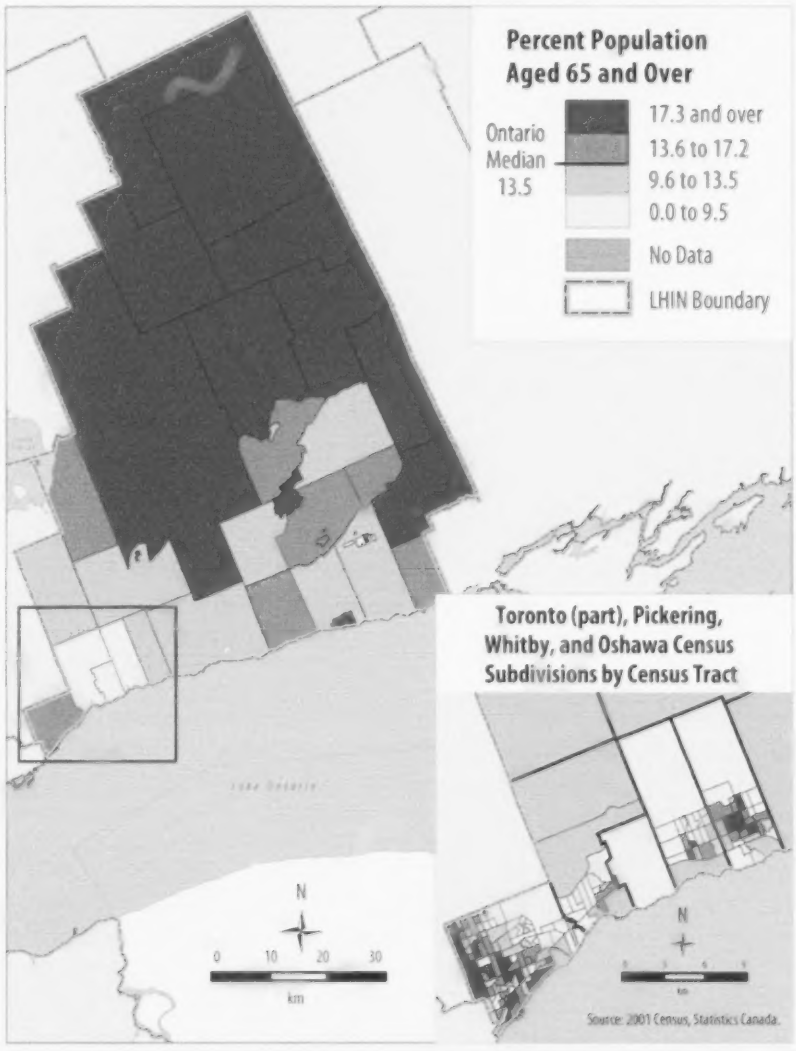
Proposals funded through the Provincial Aging at Home Strategy – announced June 2008

- Funding was announced for twenty-seven (27) projects to allow seniors to live healthy, independent lives in the comfort and dignity of their own homes. Proposals submitted by health service providers were reviewed based on their alignment with the Integrated Health Service Plan (IHSP) and included services such as expanded transportation and meals on wheels programs; services for seniors with hearing impairments or vision loss; exercise programs; expanded and new adult day service; respite programs and supportive housing services.

Supportive Housing Priority Project Report – completed

- To better understand the role that supportive housing plays in the continuum of care and further, to assist in determining future investment opportunities in Central East, a Project Team researched, explored and recommended leading

Percent Population Aged 65 and over



Source: MOHLTC Health Analytics Branch

practices/approaches to supportive housing and initiated development of a fair, transparent and supportable basis for determining where supportive housing should be available/enhanced in Central East. (http://www.centraleastlhin.on.ca/Page.aspx?id=94&ekmensel=e2f22c9a_72_206_94_2)

Community Support Services (CSS) Review Priority Project Report – completed

- To bolster the CSS sector's sustainability as a more equitable component of the health and support system across Central East, a Project Team assessed current CSS infrastructure and resources, recommended where to invest in CSS sector, identified barriers and innovative opportunities in the CSS sector, recommended strategies for enhancing integration and began to identify the appropriate human resources (paid and volunteer) required to sustain and grow the CSS sector responsibly. (http://www.centraleastlhin.on.ca/Page.aspx?id=94&ekmensel=e2f22c9a_72_206_94_2)

Caregiver Supports and Well-being Priority Project Report – completed

- In recognition that Caregivers are an essential part of the health care continuum, this project's purpose was to ensure that caregivers are provided the right support, at the right time, in the right place. The project's aim was to support caregivers more effectively and to build the capacity of individuals and families to be caregivers. The Project Team acknowledged and validated issues and needs specific to caregivers. The project identified best practices and opportunities for integration of caregiver supports through examination of what exists and what is not currently in place. The project delineated the system of caregiver support required for the Central East LHIN. (http://www.centraleastlhin.on.ca/Page.aspx?id=94&ekmensel=e2f22c9a_72_206_94_2)

Home at Last (HAL) Priority Project – transitioning from a project to a program

- While there may come a time in everyone's life when they will require the services offered in a hospital setting, most people are glad to return to their own homes as quickly as possible to heal and recuperate. This issue becomes pronounced in the aging population as seniors remaining longer than necessary in an acute care environment can cause more harm than good. The Project Team has designed and is continuing to deliver a plan for rolling out the HAL program at the Durham and Scarborough hospital sites in the Central East LHIN by April 2009. (http://www.centraleastlhin.on.ca:/Page.aspx?id=10252)

Chronic Disease Prevention and Management

Lakeridge Health Oshawa designated as a District Stroke Centre – November 2008

- The Central East LHIN, with the support of the Ontario Stroke Network, designated Lakeridge Health Oshawa as a District Stroke Centre. Funding received with the designation allowed the hospital to hire specialized clinical staff and purchase clot busting drugs, commonly called t-PA, which can be quickly administered to minimize the effects of a stroke. Lakeridge Health partnered with the existing District Stroke Centre at the Peterborough Regional Health Centre to begin building a unified Stroke System in the Central East LHIN. The designation means close to home care for Durham Region stroke patients who previously had to travel to Toronto, Barrie, York Region or Peterborough to access these services.

Early Identification, Intervention and Integration of Chronic Disease Prevention & Management (CDPM) within the Chronic Kidney Disease (CKD) population in the Central East Local Health Integration Network (CE LHIN) – in progress

- The overall purpose of this initiative is to identify populations at high risk of developing CKD, prevent new and/or manage existing co-morbid conditions and enhance health related quality of life and health care experience in this specific CKD patient population; in doing so, overall health care costs within the CE LHIN will be reduced. – (http://www.centraleastlhin.on.ca/GetInvolved.aspx?id=13042)

Self Management for Consumers/Caregivers Priority Project – transitioning from a project to a program

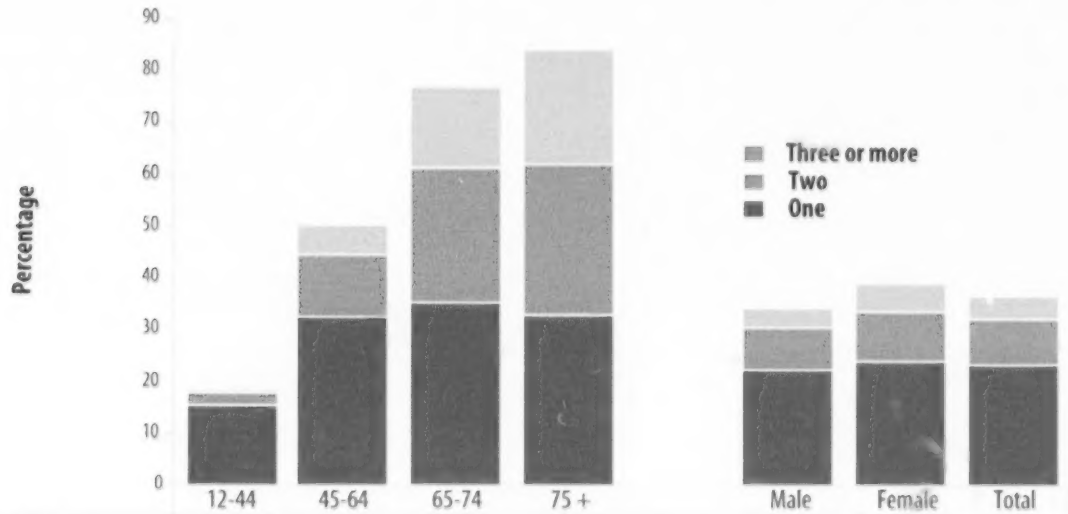
- Self-management is defined as a patient-centred, collaborative approach to care that promotes patient activation, education and empowerment. Improving an individual's ability to self-manage their chronic

condition is recognized as a contributor to consumer health and well-being and increasingly, the sustainability of the health care system. Working with the Central East Community Care Access Centre as the Lead Program Sponsor Agency, the Project Team partnered with existing agencies to educate and train individuals in the Stanford Chronic Disease Self Management Program. This Chronic Disease Self-Management Model (CDSM) was introduced as the standard across the Central East region and was delivered in community and health care settings to approximately 450 people in the first year of the project. (www.healthylifeworkshop.ca).

Diabetes 2008 Clinical Practice Guidelines Rollout Priority Project - completed

- The Project Team developed and distributed 16,000 copies of a Diabetes Resource Guide entitled "Living with Diabetes – What you should know" to increase the profile of diabetes, diabetes services and implementation of the 2008 Clinical Practice Guidelines. The Project Team also worked to enhance coordination amongst diabetes stakeholders and ensure a consistency of practice across the CE LHIN by hosting a number of knowledge sharing events for clinicians and diabetes educators. (http://www.centraleastlhin.on.ca/Page.aspx?id=10472)

Population aged 12+ reporting one, two or three or more of selected chronic conditions, by age groups and sex, Ontario, 2005.



	12-44	45-64	65-74	75 +	Male	Female	Total
Three +	0.5	5.8	15.9	22.2	3.9	5.3	4.6
Two	2.6	11.8	25.9	29.1	8.1	9.6	8.9
One	15.0	32.2	35.0	32.6	21.9	23.7	22.8

Source: 2005 Canadian Community Health Survey, Statistics Canada, Ontario Share File.

Mental Health and Addictions

Addiction Environmental Scan - completed

- The environmental scan was to assist addiction service providers in the CE LHIN and all organizations involved in service provision to the addiction and concurrent disorders client populations to engage in evidence-based planning of addiction services. The Scan produced data related to: Service needs within communities; Burden of illness related to addictions; Addiction; Collaboration and integration opportunities

among addiction services, community and hospital based mental health providers and primary care practitioners (FHT, CHC, hospitals); and, Identification of needed addiction services in CE LHIN. (http://www.centraleastlhin.on.ca/Page.aspx?id=94&ekmensel=e2f22e9a_72_206_94_2)

Wellness Recovery Action Plan (WRAP) – on-going

- WRAP is a specific education program aimed at building the capacity of people with mental health issues to manage their own issues from a Peer perspective. The CE Consumer Survivor Initiative (CSI) Network submitted a proposal to the CELHIN to provide these groups to the Community via specific funding that would cover training and resource costs. This funding resulted in over 150 people with Mental Health issues receiving this training. These self-management tools have been shown to reduce Emergency room visits and improve overall health outcomes for those dealing with mental illnesses.

Early Intervention for Youth with Mental Health and/or Addiction Needs Priority Project – completed

- This project was identified as a significant need to deal with the current challenges in transitioning youth between adolescent mental health and adult mental health services. Unnecessary delays in early identification, treatment, continuous care planning and the "hand-off" of care from one provider to the next can be the result of service providers being unable to efficiently respond to transitioning. The Project Team researched existing strategies for prevention and health promotion and began to establish partnerships across the Central East LHIN to create "client journey maps" and standardized protocols related to youth transitioning into adult mental health and addictions services. (http://www.centraleastlhin.on.ca/Page.aspx?id=10256)

Disordered Eating Priority Project – ongoing

- The Project Team is continuing to support education and awareness activities on disordered eating/eating disorders. The Team is identifying best practices and preferred models for transition between acute care and community settings for care and is developing best practices and models for on-going support for caregivers. (http://www.centraleastlhin.on.ca/Page.aspx?id=10414)

Acute Mental Health Separations, Days & Average Length of Stay (ALOS), Central East & Ontario Hospitals

Hospitals	Separations	Acute		Total	
		Days	ALOS	Days	ALOS
Durham					
Lakeridge Health-Bowmanville	48	186	3.9	253	5.3
Lakeridge Health-Oshawa‡	1,184	13,465	11.4	14,696	12.4
Lakeridge Health-Port Perry	31	234	7.5	418	13.5
Markham Stouffville-Uxbridge Site	32	183	5.7	183	5.7
Rouge Valley Health System-Ajax Site‡	645	6,763	10.5	7,652	11.9
Haliburton					
Haliburton Highlands Health Services-Haliburton	12	78	6.5	78	6.5
Kawartha Lakes					
Ross Memorial	116	1,175	10.1	1,392	12.0
Northumberland					
Campbellford Memorial	72	537	7.5	1,051	14.6
Northumberland Hills	98	503	5.1	668	6.8
Peterborough					
Peterborough Regional Health Centre‡	905	11,664	12.9	12,948	14.3
Toronto					
Rouge Valley Health System-Centenary‡	1,379	13,263	9.6	13,418	9.7
Scarborough Hospital-Grace Site‡	840	8,915	10.6	9,678	11.5
Scarborough Hospital-Scarborough General Site‡	1,028	8,022	7.8	8,932	8.7
Total Central East	**6,390**	**64,988**	**10.2**	**71,367**	**11.2**
Ontario	**57,683**	**621,495**	**10.8**	**696,049**	**12.1**

Source: Inpatient Discharges data, MOHLTC, Provincial Health Planning Database, 2004/05
‡Had acute psychiatry beds as at March 31, 2005

Community Engagement Activities

The activities of the Central East LHIN are supported by the commitment, knowledge and passion of hundreds of local individuals participating on our Planning Partnerships; self formed networks and Project Teams. A record of these activities can be seen by clicking on the Calendar page on the Central East LHIN website. (http://www.centraleastlhin.on.ca/showcalender.aspx?ekmensel=e2f22e9a_72_196_btnlink)

Planning and Engagement Collaboratives

A Collaborative is a local advisory team consisting of 9 to 15 people who provide and/or receive health care services in a specific community. Collectively, these teams approximate the continuum of the health care system with members from primary care, hospitals, community services, mental health and addiction services, long-term care, physicians, and pharmacists. Local residents interested in the public health care system also participate. (http://www.centraleastlhin.on.ca/GetInvolved.aspx?id=576)

Zone 1 - Haliburton Highlands Collaborative
Zone 2 - Kawartha Lakes Collaborative
Zone 3 - Peterborough City and County Collaborative
Zone 4 - Northumberland/Havelock Collaborative
Zone 5 - Durham East Collaborative
Zone 6 - Durham West Collaborative
Zone 7 - Durham North/Central Collaborative
Zone 8 - Scarborough Agincourt Rouge Collaborative
Zone 9 - Scarborough Cliffs Centre Collaborative
Cross Zone - French Language Health Services (FLHS) Collaborative

Francophone Initiatives

In May 2008, the Central East LHIN, in partnership with the Ministry's Regional Consultant for French Language Health Services (FLHS), established a FLHS Collaborative, an action identified in the Integrated Health Service Plan. Unlike the other Collaboratives, which are geographically specific, the French Language Health Services Collaborative represents the entire French community in the Central East LHIN. Eight dedicated individuals, with cross-sectored experience in health care and community services, have joined this collaborative and are providing advice to the LHIN on the needs of francophone residents.

Aboriginal Initiatives

The Central East LHIN is a diverse region that includes several First Nations: Alderville First Nation, Curve Lake First Nation, Hiawatha First Nation and Mississaugas of Scugog Island First Nation. There are other Aboriginal peoples throughout the LHIN area including Métis and Inuit. The First Nation communities combine for a total of approximately 12,000 residents. In 2008/09, the Central East LHIN reached out to the local First Nations, Métis and off-reserve Aboriginal communities to identify opportunities for better communication and collaborative planning.

Building on discussions held in previous years and endorsed by Aboriginal representatives, the Central East LHIN began to develop the "Health Advisory Circle" in the first three months of 2009. The Circle will provide advice to the LHIN on goals, priorities and programs that are culturally, socially and historically relevant as the LHIN continues to plan, co-ordinate, integrate and fund the local health care system.

On March 3rd, 2009, the LHINs of the Greater Toronto Area (GTA) collaborated in planning an engagement event with the GTA Aboriginal community at the Native Canadian Centre of Toronto. Participants represented Aboriginal agencies and programs throughout the GTA – the LHINs and the community connected based upon a shared vision of improving the health status of urban Aboriginal peoples.

Utilizing a cultural approach to community engagement, the LHINs presented recommendations on foundations for a collective approach to future engagement strategies, based upon key informant interviews conducted in 2008. These recommendations were the basis for the breakout group discussions surrounding the foundation for future engagement.

The outcome of the event was very positive: 90% of the participants felt that the session "gave them the opportunity to participate and express their views", and over 80% of the participants felt that the "session was a success."

LHIN-wide Networks

Like Collaboratives, Network membership represents the continuum of health care services. Unlike the Collaboratives, however, Networks bring together a single team from across the LHIN on a specific priority area identified in the IHSP. For the most part, Networks are the generative bodies for new strategic directions that will improve service integration and quality of care for their priority communities. Networks are guided by a steering committee of 12 to 15 individuals with specific interests and skills related to the priority. The steering committee acts as a conduit between the LHIN and the broader Network – which can also be defined as a community of interest. The broader Networks are not limited in their size.
(http://www.centraleastlhin.on.ca/GetInvolved.aspx?id=632)

Seamless Care for Seniors Network
Chronic Disease Prevention and Management Network
Mental Health and Addiction Network

In November 2008, the Central East Hospice Palliative Care Network formed after members of the hospice palliative care sector within Central East embarked on a process to integrate the three predecessor End-of-Life Care Networks operating in Central East (Durham Region End-of-Life Care Network; Haliburton, Kawartha and Pine Ridge End-of-Life Care Network; and Toronto Palliative Care Network-East Region). A Planning Framework and Terms of Reference for the new network have been developed, as well as the identification of the inaugural Steering Committee. (http://www.centraleastlhin.on.ca/GetInvolved.aspx?id=12934)

Task Groups/Working Groups

Task groups are time-limited action teams established to address common issues or opportunities common to the Networks (i.e., priority areas) and Collaboratives. They consist of members with specific expertise related to the subject, and are drawn from all corners of the Central East LHIN. For example, the **Primary Care Working Group** consists of physicians, nurses and other allied health professionals that serves as a leading primary care resource on issues related to our health care priorities. These groups include:
(http://www.centraleastlhin.on.ca/GetInvolved.aspx?id=634)

Emergency Department Performance Task Group
Alternate Level of Care Task Group
Rehabilitation Services Task Group
Primary Care Working Group
eHealth Steering Committee

Health Professionals Advisory Committee (HPAC)

In 2008, the Central East LHIN established a **Health Professionals Advisory Committee (HPAC)**. These new committees, which are now in place in each LHIN, are responsible for assisting the LHIN in carrying out its responsibilities by providing advice on how to achieve patient-centered health care. The fourteen (14) members of the Central East LHIN HPAC include physicians, nurses and allied health professionals from across the LHIN. The group works directly with the Chief Executive Officer to review LHIN activities and offer advice.
(http://www.centraleastlhin.on.ca/Page.aspx?id=10178&ekmensel=e2f22c9a_72_184_10178_5)

Other Engagement Activities

In April and May, 2008 the Central East LHIN supported the **Rouge Valley Health System** as it began to engage its communities on the implementation of a new Mental Health and Addictions Service Delivery model. This included participating in focus groups, a large Town Hall meeting and gathering feedback through surveys and emails. (http://www.centraleastlhin.on.ca/GetInvolved.aspx?id=4976)

In June 2008, the Central East LHIN hosted its second **Annual Symposium**: "Authenticity, Abundance and Alignment." Planning partners, community residents and health care providers from across the entire region were invited to the three day event which saw close to 400 people attending the opening night reception and more than 300 people participating in workshops and planning meetings. The event served as a kick off to the new Board to Board Engagement project (see below) and also introduced participants to the "Triple Aim" initiative from the Institute of Healthcare Improvement. (http://www.centraleastlhin.on.ca/GetInvolved.aspx?id=5150)

Immediately following the symposium, the LHIN, in partnership with its hospitals and Community Care Access Centre, began a **Hospital Clinical Services Plan** project. Over 150 clinical stakeholders – doctors, nurses, allied health professionals, administrative leaders – participated in an extensive community engagement process to develop the Plan. A steering committee of over 20 health care leaders was established to oversee the project and a number of advisory groups were tasked with the responsibility of developing a hospital clinical services framework and bringing forward plans for the delivery of selected surgical and medical services where issues of quality and access were of greatest concern. The groups began meeting in June 2008 and the Plan was presented for information to the Board of the Central East LHIN in February 2009. A sixty-day consultation period with the broader community began immediately after the report was presented to the Board. Hospitals will continue to undertake community engagement activities as they move forward with developing implementation plans in the coming fiscal years.

In early September 2008, staff from the Central East LHIN hosted three **Multi-sectoral Accountability Agreement education sessions** with representatives from the Community Care Access Centre, community health centres, community support services, and mental health and addiction agencies. These sessions were designed to introduce health service providers to the accountability agreement process and answer their questions.

On Sept. 22, 2008, the Ontario Medical Association and the Central East LHIN co-sponsored a **Physician Engagement Workshop** so physicians could learn about the Central East LHIN, its planning partner structures, and key initiatives and priorities. It also gave participants an opportunity to discuss how physicians and the LHIN can continue to build successful working partnerships. The workshop was developed by a joint planning committee and brought together 45 people from key groups, including 27 physicians from the area.

In the fall of 2008 and again in the spring of 2009, the Central East LHIN Board of Directors met with their governance colleagues from Central East LHIN Health Service providers as part of a **Board to Board Engagement Strategy**. Three Board to Board Collaboratives – Scarborough, Durham, and Haliburton, Kawartha, Northumberland, Peterborough - north east region – were established with the goal of creating a culture of cooperation where each health service provider understands their contribution to the overall health system and its performance. It provided a forum for joint strategic planning and the identification of integration opportunities and the sharing of best practices and tools to raise the bar of health care governance. The Board to Board Collaboratives were supported in this work by the development of a province-wide "LHIN/HSP Governance Resource and Toolkit for Voluntary Integration Initiatives."

In January 2009, the Community Support Services Review Priority Project and the Supportive Housing Priority Project joined forces to hold a successful community engagement event with **more than 100 members from community agencies** in attendance.

1. Feedback was collected on CSS integration strategies and CSS back office functions.
2. Also discussed, was the inventory of supportive housing and process improvement opportunities.
3. The input collected on these strategies was included in the final reports of these projects.

In March 2009 the Scarborough Cliffs Centre and the Scarborough Agincourt Rouge Collaboratives jointly hosted an engagement session with **Long Term Care Homes** in the Scarborough Community. In addition to gaining feedback on challenges and opportunities facing this sector, LHIN staff began the education process on the development of Accountability Agreements with this sector.

Staff and Board members from the Central East LHIN attended public meetings as part of the LHIN's **Speakers' Bureau** program and continued to welcome any opportunity to speak with community groups to answer any questions about the Central East LHIN and provide information on how people can be involved in local health planning. This included presentations to a number of **local and regional government councils** including the Region of Durham, the Town of Ajax, the Town of Uxbridge, the Town of Whitby and others.

Integration Activities

One of the main goals of each LHIN is the integration of health care services to create a more efficient health care system while at the same time improving the health care experience by creating a seamless system of care.

In 2008/09 the CE LHIN continued to support Voluntary Integration Planning by developing and enhancing the following processes:

1% Challenge – (http://www.centraleastlhin.on.ca/Page.aspx?id=6820)

- At the June 2008 Symposium the Central East LHIN launched the 1% Challenge with a goal of reinvesting $10.3 million of current hospital expenditures to CE LHIN funded community health service providers by December 2010. The challenge was issued to not only Central East LHIN hospital providers, but to CE LHIN community providers to be consistent with the Local Health System Integration Act (LSIA) that requires health service providers to identify "voluntary integration opportunities." During 2008/09 ten proposals were submitted for review and three moved forward with the development of project charters and business cases.

  These included:
  Supportive Housing for Ventilator-Assisted Individuals
  Transitional Care Unit for ALC Patients
  Non Urgent Transportation

Health System Improvement Pre-Proposals (HSIP) – (www.centraleastlhin.on.ca)

- This process has been designed to reduce the time and costs Health Service Providers incur in preparing detailed business cases for additional funding. H-SIPs enable the LHIN to make a preliminary assessment of any request or activity contemplated by a Health Service Provider that requires the LHIN's approval. An online submission tool, created by staff in the Central East LHIN organization, was designed to streamline the application process.

CE LHIN Project Management Office – (http://www.centraleastlhin.on.ca/report_display.aspx?id=7804)

- To support this project management philosophy and process, the Central East LHIN created a Project Management Office (PMO) to ensure that projects can be aligned and supported in one cohesive structure and process. In 2008/09 this supported an efficient work flow as projects were presented to the Central East LHIN Board of Directors for decision making or funding approval. It also provided an effective, transparent and consistent process to support the Central East LHIN's goals of shared communication and transformational leadership.

Governance Toolkit – (http://www.centraleastlhin.on.ca/report_display.aspx?id=8506)

- In September 2008 the Central East LHIN, along with the Central West LHIN, South East LHIN, Eric St. Clair LHIN and Central LHIN, and the Ontario Health Providers Alliance (OHPA) and the Ontario Association of Community Care Access Centres (OACCAC), released the "LHIN/HSP Governance Resource and Toolkit for Voluntary Integration Initiatives." The purpose of the toolkit is to:

    - Assist health service provider boards to understand evolving LHIN practices, processes and expectations arising from interpretations and applications of the act as illustrated by the experience of the participating LHINs;

    - Support health service provider boards in understanding their respective roles and responsibilities in providing appropriate leadership to their organizations and in developing strategies to work with one another and with the LHIN Boards on voluntary integration initiatives.

LHIN INITIATIVES IN SUPPORT OF GOVERNMENT PRIORITIES

ER Wait Times Initiatives

Important to the health care system and to hospitals in the Central East LHIN is decreasing patient flow times for treating and discharging patients through CE LHIN emergency departments. To help achieve this, the **Emergency Department Task Group** was created to examine internal hospital practices and strategies with a goal to improve ED efficiency and reduce wait times. This includes patient flow practices, physician resources, team approaches to patient care, access to diagnostic services, ambulance off-load times and on-call coverage.

The Emergency Department Task Group, which includes members from hospitals across the LHIN, a mental health facility, the community care access centre (CE CCAC), emergency medical services (EMS), LHIN senior staff, planning partners and consultants, began meeting in May 2007 and in June 2008 released its "Emergency Department Task Group Report."

With a vision statement of delivering *"The Best Emergency Care Everywhere."* the membership established five priority recommendation areas that include:

Patient Flow in ED
Staffing/Human Resources
Transportation service (s)
Protected ED Budget
Staff Safety/Security

Implementation of these recommendations in 2008/09 has resulted in:

LEAN processes being established in most hospitals
Patient Transportation projects
A LHIN-wide focus on ED staff safety and security
ED Pay for Results funding to six CE LHIN hospitals as designated by the Ministry of Health and Long-Term Care which rewards designated hospitals for meeting specific ER wait time reduction targets.

Improving the ALC Situation

Alternate Level of Care is a priority across the province and in the Central East LHIN. ALC is a complex, serious system issue that impacts patient access to care, patient safety, and patient quality of life. It is costly to the health and well-being of the patient and their loved ones, and it is costly to the health care system. In 2008/09 the ALC occupancy rate in acute care beds in Central East LHIN hospitals had been reported to be about 18% which is equivalent to more than 165 hospital beds being used by patients who do not require acute care, but who cannot be safely discharged. The majority of these patients (more than 40%) were people 80 years of age or older waiting for placement in a long term-care home.

To address this issue, the Central East LHIN's ALC Task Group was created. It is a collaboration of 16 organizations involved in providing health care in the home, in the hospital, in long-term care, in sub-acute care settings and community care settings. The ALC Task group membership includes hospitals (general and tertiary), CCAC, long-term care homes and community support services. It began working on a Central East LHIN ALC Action Plan in May 2007. After a year of hard work, the Task Group presented its report at the Central East LHIN Symposium in June 2008. Based on analytical discussions, qualitative and quantitative data collection, review of provincial and other reports, and feedback from the community consultation processes, the Central East LHIN ALC Task Group created **52 recommendations**, which were organized into six themes:

1. Presentation at Hospital: Risk Identification and Early Intervention
2. Patient Flow and Communication in Hospital: Acute and Post-Acute Care
3. System Access and Smooth Transitions across Continuum of Care
4. Community Capacity and In-Home Care
5. Health Human Resources
6. ALC System Monitoring and Evaluation

Of the 52 recommendations, 13 have been identified as immediate priorities. Even in the face of an increasing trend, these recommendations have the potential to **reduce the ALC volumes** while pursuing the vision of "Right Care, Right Place, Right Time" for the residents of the Central East LHIN. The 13 priorities that have been identified for immediate implementation are:

1. Utilize standardized risk screening and assessment tools for early identification
2. Provide specialized staff resources in each hospital Emergency Department
3. Implement a Central East LHIN standard policy framework
4. Expand definition and recognition of ALC beyond acute care bed spaces
5. Provide in-hospital activation/exercise program to maintain optimal functioning
6. Increase the availability of housing by using retirement homes and/or supportive housing
7. Create Behavioural Support Unit(s) within LTCHs that include short-stay transitional beds
8. Implement enhanced/comprehensive community services discharge planning process
9. Increase community support services for in-home personal support, homemaking and caregiver respite
10. Develop a Health Human Resource Strategy
11. Undertake a research study to determine the percentage of hospital patients waiting for a LTCH placement that could be cared for elsewhere more appropriately
12. Create a Central East LHIN Alternate Level of Care Implementation Committee
13. Extend CCAC service maximums

In 2008/09 progress was made in several areas including initiating the early identification assessment tool in some hospitals with the LHIN-wide application to be coordinated by the Health Service Provider's Implementation Team; specialized staff have been provided in the form of seven **Geriatric Emergency Management** nurses and through the creation of the **nurse practitioner outreach team long term care**; a pilot project was developed to provide an in-hospital **activation/exercise program** to maintain optimal functioning; and there was interest to increase the **availability of housing** by using retirement homes and/or supportive housing.

- A Nurse Practitioner Outreach Steering Committee was established under the ALC/ED/Wait Times portfolio with the purpose to co-ordinate and oversee the initiation, co-ordination and evaluation of the three Nurse Practitioner Outreach Projects (the team includes Haliburton Kawartha Pine Ridge, Durham and Scarborough). In 2008/09 a coordinated recruitment strategy was launched, a project charter was drafted and a project manager was identified to support the project.

- The ALC Client Activation project was designed and initiated at Ross Memorial Hospital in the City of Kawartha Lakes and has been operational since the end of 2008. The project will wrap up within the first few months of 2009/10 and a report to the CE LHIN will be forthcoming shortly thereafter.

- An ALC Assessment and Coaching team was developed to investigate and support the Peterborough Regional Health Centre (PRHC) in reducing ALC pressures. The peer-review team will report in June 2009 and included experts from across the LHIN, PRHC staff, LHIN senior staff and a Geriatrician from outside the LHIN.

- The expansion of the Wait time Information System (WTIS), which will soon include the collection of data

on ALC patients, was announced and will be implemented in hospitals across the province by spring of 2011. In the Central East LHIN, Rouge Valley Health System (RVHS) was selected and has agreed to participate in the initial phase of the project. RVHS will be playing a critical role in the development of functional, reporting and technical business requirements for the WTIS-ALC solution.

The Clinical Services Plan

To address challenges related to access, quality and sustainability the CE LHIN and the nine hospital corporations within its boundaries worked together to create a Clinical Services Plan (CSP). Over 150 health care professionals worked together in five Advisory Groups, to develop recommendations that will improve health care delivery in:

- Cardiac services (diagnosis, treatment and rehabilitation)
- Maternal Child Youth services (obstetrics, paediatrics and children up to 19 years of age)
- Mental Health and Addiction services (emergency treatment, admission and follow-up)
- Thoracic Surgery (focusing primarily on cancer surgery in the chest)
- Vascular Surgery (for leg amputations, blood clots, aneurysms)

This project got underway at the June 2008 Symposium and was guided by a project charter. A Project Steering Committee, comprised of senior clinical and administrative leaders from across the LHIN supported the work of the front line members of the Advisory Groups.

To guide the discussions and provide consistency in decision-making, the CE LHIN established the following themes for the Advisory Groups as they developed their recommendations. These included:

- Adopting a "systems" focus that respects local access and local governance
- Using evidence to determine "appropriateness" of local access versus regional and provincial access
- Promoting innovation and a relentless focus on quality and patient safety
- Advancing the concept of mutuality of support between CE LHIN providers
- Promoting the sustainability of the public health system

The "Hospital Clinical Services Plan - Detailed Report" was submitted to the Board of the Central East LHIN on February 17, 2009. In submitting the report, Dr. George Buldo, Chair of the Clinical Services Plan (CSP) Steering Committee spoke about how newly formed teams came together during this project to develop proposals that will benefit patients and health care providers in the Central East LHIN.

The report contains 28 clinical service delivery model recommendations and details on three medical leadership frameworks. All the recommendations and frameworks are aligned with the vision of a "One Acute Care Network" to provide quality, accessible, sustainable health care to the residents of the Central East LHIN. A 60-day consultation period, which began on February 18th, was designed to gather feedback from across the LHIN and will help inform the hospitals as they move forward with implementing the recommendations in the report.

Transportation was identified as a key enabler in the Clinical Services Plan for effective management of patients across Central East LHIN and to other LHINs for care when appropriate. Transportation was also a top priority recommendation from the Central East LHIN Emergency Department Task Group. Activities related to this initiative in 2008/09 included Non-Urgent and Clinical Services Planning Transportation – Request for Proposals led by Campbellford Memorial Hospital on behalf of hospitals; multi-partner meetings with Northumberland and Peterborough EMS to discuss a non-urgent transport LHIN funded project to pursue efficacy of enhanced joint hospital/community non-urgent transportation service in City of Kawartha Lakes; a Rural Transportation Priority Project – reviewing transportation practices of community support agencies in rural areas; the Scarborough Transportation Initiative – reviewing transportation practices of community support agencies in urban area; the

Home at Last Priority Project – LHIN-wide initiative to support eligible patients with necessary supports, including transportation.

For more information, please see (http://www.centraleastlhin.on.ca/Page.aspx?id=7096)

ANALYSIS OF CE LHIN OPERATIONAL PERFORMANCE

In 2008/09 the Central East LHIN operational budget was $4.6M. The LHIN ended the year with a surplus of $14,157, hitting the 1% objective target. During the year, additional staff was hired to support planning and integration, contract and funding responsibility as well as its financial and administrative requirements. The total number of staff as of March 31, 2009 was 28. The facility was renovated to accommodate the additional staff.

Staff continued to focus on activities related to the Ministry LHIN Accountability Agreement (MLAA) in partnership with its many stakeholders. Funding for special projects allowed the LHIN to pursue E-Health activities, aboriginal planning and ED/ALC initiatives.

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AUDITORS' REPORT

To the Members of the Board of Directors of the Central East Local Health Integration Network

We have audited the statement of financial position of the Central East Local Health Integration Network (the "LHIN") as at March 31, 2009 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Central East Local Health Integration Network as at March 31, 2009 and the results of its operations, its changes in its net debt and its cash flows for the year then ended, in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 8, 2009

Statement of Financial Position

as at March 31, 2009

	2009	2008
	$	$
Financial assets		
Cash	**1,249,277**	1,598,513
Due from Ministry of Health and Long Term Care ("MOHLTC")	**1,485,300**	7,013,110
Accounts receivable	**6,187**	-
	2,740,764	8,611,623
Liabilities		
Accounts payable and accrued liabilities	**1,230,297**	742,425
Due to Health Service Providers ("HSP")	**1,485,300**	7,013,110
Due to MOHLTC (Note 3b)	**28,950**	869,115
Due to the LHIN Shared Services Office (Note 4)	**7,546**	1,844
Deferred capital contributions (Note 5)	**380,725**	309,822
	3,132,818	8,936,316
Net debt	**(392,054)**	(324,693)
Non-financial assets		
Prepaid expenses	**11,329**	14,871
Capital assets (Note 7)	**380,725**	309,822
	392,054	324,693
Accumulated surplus	**-**	-

Approved by the Board

_____ Director

_____ Director

Statement of Financial Activities

year ended March 31, 2009

	Budget (unaudited) (Note 8)	2009 Actual	2008 Actual
	$	$	$
Revenue			
Ministry of Health and Long Term Care ("MOHLTC") funding			
Health Service Provider ("HSP") transfer payments (Note 9)	**1,805,882,796**	**1,837,250,608**	1,718,681,252
Operations of LHIN	**4,610,029**	**4,329,312**	3,741,617
Aging at Home (Note 10a)	-	-	288,000
Emergency Department ("ED") Lead (Note 10b)	-	**75,000**	43,800
Emergency Room/Alternative Level of Care ("ER/ALC") (Note 10c)	-	**33,300**	70,000
Aboriginal Planning (Note 10d)	-	**32,250**	20,000
E-Health (Note 10e)	-	**700,000**	475,000
Amortization of deferred capital contributions (Note 5)	-	**209,814**	172,200
	1,810,492,825	**1,842,630,284**	1,723,491,869
Expenses			
Transfer payments to HSPs (Note 9)	**1,805,882,796**	**1,837,250,608**	1,718,681,252
General and administrative (Note 11)	**4,610,029**	**4,524,969**	3,453,781
Aging at Home (Note 10a)	-	-	122,503
ED Lead (Note 10b)	-	**75,000**	40,043
ER/ALC (Note 10c)	-	**33,300**	70,000
Aboriginal Planning (Note 10d)	-	**32,015**	-
E-Health (Note 10e)	-	**685,442**	436,194
	1,810,492,825	**1,842,601,334**	1,722,803,773
Annual surplus before funding repayable to the MOHLTC	-	**28,950**	688,096
Funding repayable to the MOHLTC (Note 3a)	-	**(28,950)**	(688,096)
Annual surplus	-	-	-
Opening accumulated surplus	-	-	-
Closing accumulated surplus	-	-	-

Statement of Changes in Net Debt

year ended March 31, 2009

	2009	2008
	$	$
Annual surplus	-	-
Acquisition of tangible capital assets	**(280,717)**	(39,490)
Amortization of tangible capital assets	**209,814**	172,200
Change in other non-financial assets	**3,542**	34,723
Decrease in net debt	**(67,361)**	167,433
Opening net debt	**(324,693)**	(492,126)
Closing net debt	**(392,054)**	(324,693)

Statement of Cash Flows

year ended March 31, 2009

	2009	2008
	$	$
Operating		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**209,814**	172,200
Amortization of deferred capital contributions (Note 5)	**(209,814)**	(172,200)
	-	-
Changes in non-cash operating items		
Decrease (increase) in due from MOHLTC	**5,527,810**	(7,013,110)
(Increase) decrease in accounts receivable	**(6,187)**	281,000
Increase in accounts payable and accrued liabilities	**487,872**	93,702
(Decrease) increase in due to HSPs	**(5,527,810)**	7,013,110
(Decrease) increase in due to the MOHLTC	**(840,165)**	688,096
Decrease in prepaid expenditures	**3,542**	34,723
Increase (decrease) in due to the LHIN Shared Services Office	**5,702**	(86,988)
	(349,236)	1,010,533
Capital transactions		
Acquisition of tangible capital assets	**(280,717)**	(39,490)
Financing		
Increase in deferred capital contributions (Note 5)	**280,717**	39,490
Net increase in cash	**(349,236)**	1,010,533
Cash, beginning of year	**1,598,513**	587,980
Cash, end of year	**1,249,277**	1,598,513

Notes to the Financial Statements

1. Description of business

The Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Central East Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2009.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The Central East LHIN is a mix of urban and rural geography and is the sixth-largest LHIN in land area in Ontario (16,673 km^2). In densely populated urban cities, suburban towns, rural farm communities, cottage country villages and remote settlements, the Central East LHIN stretches from Victoria Park to Algonquin Park. The neighbourhoods in our planning zones boast a rich diversity of community values, ethnicity, language and socio-demographic characteristics.

The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable, expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets.

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any MOHLTC managed programs.

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as capital assets, are recorded as deferred capital revenue and are recognized over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office furniture and fixtures	5 years straight-line method
Web development	3 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year.

Significant accounting policies (continued)

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any excess of funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

	Revenue	Expenses	2009 Surplus	2008 Surplus
	$	$	$	$
Transfer payments to HSPs	**1,837,250,608**	**1,837,250,608**	**-**	-
LHIN operations	**4,539,126**	**4,524,969**	**14,157**	460,036
Aging at Home	**-**	**-**	**-**	165,497
ED Lead	**75,000**	**75,000**	**-**	3,757
ER/ALC	**33,300**	**33,300**	**-**	-
Aboriginal Planning	**32,250**	**32,015**	**235**	20,000
E-Health	**700,000**	**685,442**	**14,558**	38,806
	1,842,630,284	**1,842,601,334**	**28,950**	688,096

b) The amount due to the MOHLTC at March 31 is made up as follows:

	2009	2008
	$	$
Due to MOHLTC, beginning of year	**869,115**	181,019
Recovery by MOHLTC during the year	**(869,115)**	-
Funding repayable to the MOHLTC related to current year activities (Note 3a)	**28,950**	688,096
Due to MOHLTC, end of year	**28,950**	869,115

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs, is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (not paid) by the LHIN at the year end are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the Shared Services Agreement the LSSO has with all the LHINs.

5. Deferred capital contributions

	2009	2008
	$	$
Balance, beginning of year	**309,822**	442,532
Capital contributions received during the year	**280,717**	39,490
Amortization for the year	**(209,814)**	(172,200)
Balance, end of year	**380,725**	309,822

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due in each of the next five years and thereafter are as follows:

	$
2010	141,154
2011	160,320
2012	186,989
2013	185,171
2014	184,903
Thereafter	288,080
	1,146,617

The LHIN also has funding commitments to HSPs associated with accountability agreements. Minimum commitments to HSPs based on the current accountability agreements are as follows:

	$
2010	1,862,209,185
2011	1,888,448,360
	3,750,657,545

7. Capital assets

			2009	2008
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Office furniture and fixtures	**424,508**	**239,576**	**184,932**	123,157
Computer equipment	**130,493**	**99,920**	**30,573**	16,255
Web development	**36,100**	**28,507**	**7,593**	19,626
Leasehold improvements	**461,553**	**303,926**	**157,627**	150,784
	1,052,654	**671,929**	**380,725**	309,822

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of Financial Activities reflect the initial budget at April 1, 2008. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $1,837,250,608 is made up of the following:

Initial budget	**1,805,882,796**
Adjustment due to announcements made during the year	**31,367,812**
Total budget	**1,837,250,608**

The total revised operating budget of $5,450,579 is made up of the following:

	$
Initial budget as represented on the statement of financial activities	**4,610,029**
Additional funding received during the year for:	
Aboriginal planning initiative	**32,250**
E-Health	**700,000**
ED Lead initiative	**75,000**
ER/ALC	**33,300**
Total budget	**5,450,579**

9. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $1,837,250,608 (2008 - $1,718,681,252) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2009 as follows:

	2009	2008
	$	
Operation of hospitals	**1,082,886,094**	1,013,569,316
Grants to compensate for municipal taxation - public hospitals	**294,975**	294,975
Long term care homes	**356,028,894**	333,744,158
Community care access centres	**195,064,667**	183,460,668
Community support services	**27,254,697**	25,343,566
Assisted living services in supportive housing	**11,996,510**	10,001,649
Community health centres	**12,267,412**	8,786,926
Community mental health addictions program	**50,100,532**	48,844,834
Specialty psychiatric hospitals	**100,271,165**	94,583,494
Acquired brain injury	**1,061,662**	-
Grants to compensate for municipal taxation - psychiatric hospitals	**24,000**	51,666
	1,837,250,608	1,718,681,252

10. a) Aging at Home

The LHIN did not receive any funding related to the Aging at Home project, this year. In the prior year the LHIN received $288,000 related to the Aging at Home project and spent $122,503.

b) ED Lead

The LHIN received funding of $75,000 (2008 - $43,800) related to the ED Lead project. ED Lead expenses incurred during the year are as follows:

	2009	2008
	$	$
Consulting services	**62,068**	40,043
Salaries and benefits	**11,086**	-
Other	**1,846**	-
	75,000	40,043

c) ER/ALC

The LHIN received funding of $33,300 (2008 - $70,000) related to the ER/ALC project. ER/ALC expenses incurred during the year consist of $33,300 (2008 - $70,000) of salaries & benefits.

d) Aboriginal Planning

The LHIN received funding of $32,250 (2008 - $20,000) related to the Aboriginal Planning project. Aboriginal Planning project expenses incurred during the year consist of $31,250 (2008 - $nil) of consulting fees and $765 (2008 - $nil) of other expenses.

e) E-Health

The LHIN received funding of $700,000 (2008 - $475,000) related to the E-Health project. E-Health project expenses incurred during the year are as follows:

	2009	2008
	$	$
Consulting services	**458,373**	435,415
Salaries and benefits	**156,903**	-
Meetings	**68,529**	-
Supplies and other	**1,637**	779
	685,442	436,194

11. General and administrative expenses

The Statement of Financial Activities presents the expenses by function, the following classifies these same expenses by object:

	2009	2008
	$	$
Salaries and benefits	**2,672,304**	2,052,281
Occupancy	**312,792**	237,354
Amortization	**209,814**	172,200
Shared services	**300,000**	302,301
Community engagement	**128,329**	85,498
Consulting services	**320,734**	263,553
Supplies	**137,970**	45,994
Board member expenses	**249,584**	172,166
Mail, courier and telecommunications	**5,007**	1,213
Other	**188,435**	121,221
	4,524,969	3,453,781

12. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 28 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2009 was $202,595 (2008 - $162,424) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation of the plan was completed for the plan as of December 31, 2008. At that time, the plan was 97% funded.

13. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act.*

14. Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1, 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and, therefore, no additional disclosure is required.

STAFF MEMBERS

Back Row

Kate Reed, Jeanne Thomas, John Lohrenz, Lindsay Wyers, Marlene Ross, Lewis Hooper, Charli Law, Ajay Thusoo, Karen O'Brien, Paul Barker

Middle Row

Marco Aguila, Susan Plewes, Nancy Hunter, Maria Grant, Emily Van de Klippe, Ritva Gallant, Linda Henry, Janet Boland, Suzette Stines-Walford, Karol Eskedjian, Katie Cronin-Wood

Front Row

Leila Tikaram, Karen Landriault, Sheila Rogoski, Deborah Hammons, Christine Laity, Jai Mills, Mai Nguyen, Jennifer Russell, Jenny Burgess, Brian Laundry

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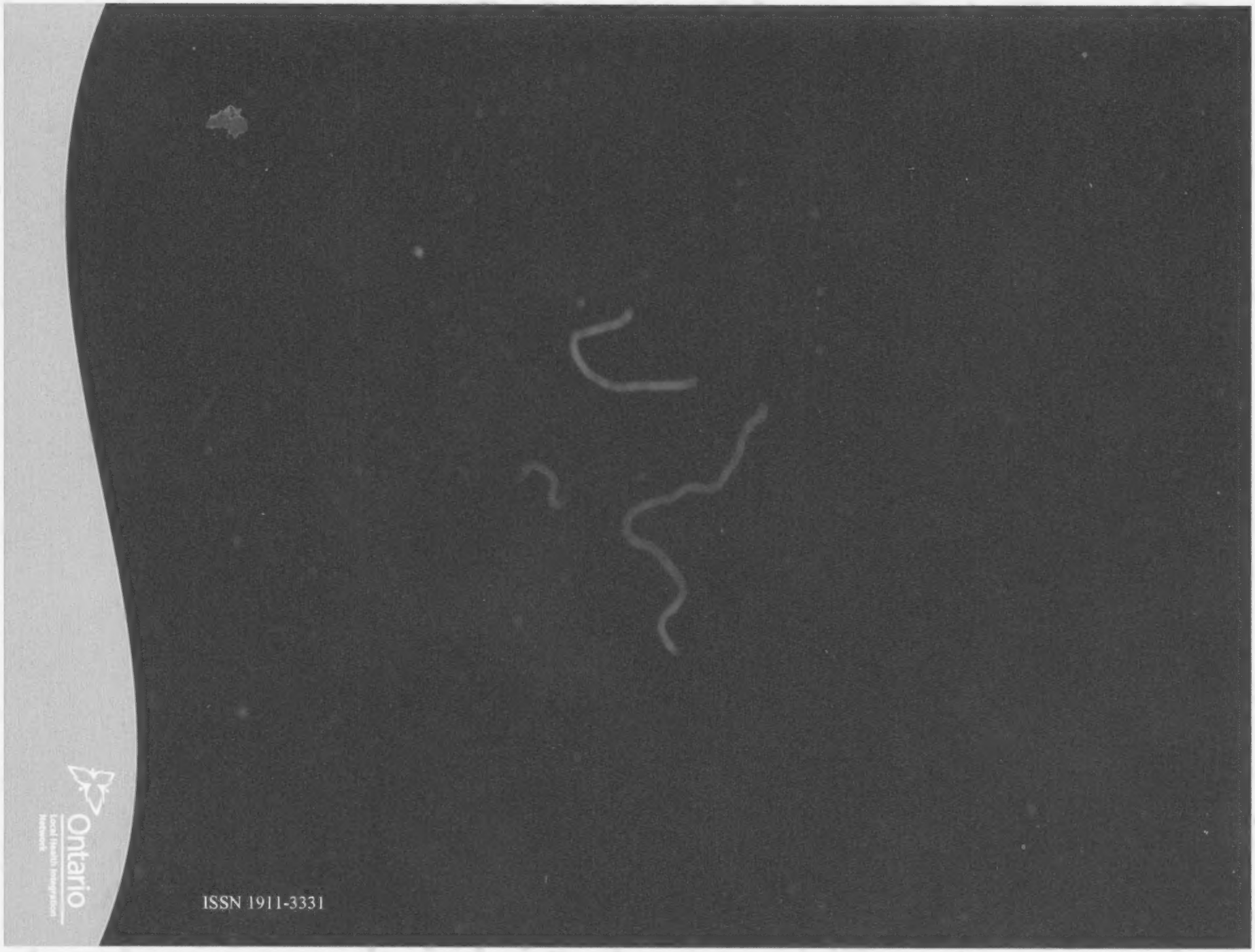

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